

FILED JUN 8 1944

Registration District No. **8544**

Primary Registration District No. **5254**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Chariton**
(b) City or town **Triphlett, Rural**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **MARY E. CRAIGG**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **2**
6. (b) Name of husband **M.E. CRAIGG**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **4 18 63**
(Month) (Day) (Year)

8. AGE: Years **80** Months **7** Days **14**
If less than one day _____ hr. _____ min.

9. Birthplace **Chariton Co Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____
12. Name **TAN COY**
13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Anderson**
15. Birthplace **Chariton Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Albert Lancaster**
(b) Address **Triphlett Mo R.F.D. Rural**
17. (a) (b) Date thereof **5/19/44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Rothville Mo**
18. (a) Signature of funeral director **W. D. West**
(b) Address **Mendon Mo**
19. (a) **5-19-1944** (b) **W. D. West**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Chariton**
(c) City or town **Triphlett Mo Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **18**
year **1944** hour **4** minute **a** M.
21. I hereby certify that I attended the deceased from **May 8**, 19**44** to **May 18**, 19**44**
that I last saw **her** alive on **May 17** h **1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetic Coma**
Duration **4 days**

Due to **Diabetis**

Due to **Senility**
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **61**
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **W. D. West** (M. D. 8888)
Address **Mendon Mo** Date signed **5 20 1944**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2
-43
-39
K35697

RECEIVED

District Health Officer No. 8

District File Number

Date Filed

6-2-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.